

**GASTROENTEROLOGY CENTER OF THE MIDSOUTH, P.C.
G.I. DIAGNOSTIC AND THERAPEUTIC CENTER, L.L.C.**

**PATIENT AUTHORIZATION
FOR USE / DISCLOSURE OF HEALTH CARE INFORMATION**

- | | | |
|---|-----------------------------|--------------------|
| <input type="checkbox"/> 3950 New Covington Pike, Suite 300 | Telephone (901) 377-2111 | Fax (901) 377-5105 |
| <input type="checkbox"/> 6005 Park Ave., Suite 323-B | Telephone (901) 684-5500 | Fax (901) 684-5518 |
| <input type="checkbox"/> 7668 Airways Blvd. | MS Telephone (662) 349-6950 | Fax (662) 349-6634 |
| Building B | TN Telephone (901) 766-9490 | |
| <input type="checkbox"/> 1407 Union Ave., Suite 1400 | Telephone (901) 272-9296 | Fax (901) 272-1786 |
| <input type="checkbox"/> 1310 Wolf Park Dr. | Telephone (901) 624-5151 | Fax (901) 624-5280 |
| <input type="checkbox"/> 1324 Wolf Park Dr. | Telephone (901) 755-9110 | Fax (901) 755-4321 |

Patient's name: _____

Address: _____

Telephone: _____ **Date of birth:** _____ **SSN:** _____

I, the undersigned, authorize and request Gastroenterology Center of the MidSouth, P.C. and /or G.I. Diagnostic and Therapeutic Center, L.L.C. to

_____ Release information to _____ Obtain information from

Name: _____

Address: _____

City, _____ State: _____ Zip code: _____

This request and authorization applies to:

- | | | |
|------------------------------|---------------------------|-----------------------------|
| ____ Complete Health Record | ____ Operative Report | ____ Lab Results |
| ____ Pertinent Documentation | ____ History and Physical | ____ Consultation Reports |
| ____ Progress Notes | ____ EKG | ____ EEG |
| ____ Discharge Summary | | |
| ____ X-Ray Report | ____ X-Ray Film / Images | ____ Photographs, Videotape |
| ____ Complete Billing Record | | ____ Itemized Bill |

Other: _____
(specify)

Drug and /or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis B or C, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and/or other sensitive information regarding counseling, treatment, rehabilitation or the risk thereof. I agree to its release.

Time Limit & Right to Revoke Authorization

Except to the extent action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Gastroenterology Center of the MidSouth, P.C. or by filling out a form supplied by GCMS known as the *Revocation of Authorization Form*. Unless revoked, this authorization will expire on the following date or event _____

_____ or one year from the date of signature, unless otherwise specified. Once GCMS gives out the information that I want released, I know that GCMS has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is not for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment.

2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

I understand I can refuse to sign this authorization. I need not sign this form to obtain medical treatment, payments, or health plan enrollment eligibility. I understand that any disclosure of information carries with it the potential for re-disclosure by the recipient and that the information may then no longer be protected by federal confidentiality rules.

Patient Signature: _____ **Date:** _____

Authority to sign, if not patient: _____

Relationship to patient: _____

GCMS Use Only

Identity of Requester Verified by:

Photo ID Matching Signature Other, specify _____

Verified by: _____
(name / title and date)